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Looking toward the future for suicide prevention

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Looking toward the future for suicide prevention

Abstract

Michael was the first born of two sons. His father expected great things from Michael, nothing short of perfection. Michael tried hard to please his father, but his father was never fully satisfied. His father thought if he yelled at Michael enough and was tough on him that Michael would eventually do things right and be molded into a "fine young man." Michael began to feel hopeless. He believed that he would never please his father. He started doing exactly the opposite of what his father told him to do because he knew he could not live up to his father's expectations. When Michael would defy his father, his father would yell at him even worse than before. It was a hopeless situation for Michael, especially when his little brother would do exactly as his parents asked. Michael often referred to his younger brother as "the perfect child." Michael felt that he would never be good enough.

LOOKING TOWARD THE FUTURE FOR SUICIDE PREVENTION

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Stacey L. Staton

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Michael was the first born of two sons. His father expected great things from Michael, nothing short of perfection. Michael tried hard to please his father, but his father was never fully satisfied. His father thought if he yelled at Michael enough and was tough on him that Michael would eventually do things right and be molded into a "fine young man." Michael began to feel hopeless. He believed that he would never please his father. He started doing exactly the opposite of what his father told him to do because he knew he could not live up to his father's expectations. When Michael would defy his father, his father would yell at him even worse than before. It was a hopeless situation for Michael, especially when his little brother would do exactly as his parents asked. Michael often referred to his younger brother as "the perfect child." Michael felt that he would never be good enough.

Michael began to drink to drown his pain and sorrow. When he was drunk, he would be wild and crazy because he had to pretend that he was happy like all of his friends. The wild and crazy Michael attracted a lot of friends. People really liked Michael because he acted so fun and carefree. These friends did not know it, but Michael was hurting deep inside. Michael soon felt like he had to drink and be crazy to keep his friends. He was afraid that they, too, would not accept the real Michael just like his dad.

Drinking soon got in Michael's way. His girlfriend said she did not like the crazy things he did when he drank. He often embarrassed her when he was drunk. Michael stopped drinking so much beer, and he started drinking non-alcoholic beer because he loved his girlfriend and wanted to please her. His girlfriend continued to drink on a regular basis herself, but she told Michael that even his effort to drink non-alcoholic beer was not good enough for her. The message Michael heard was "I am not good enough!" This was the message he had heard his whole life. He believed that the

people he cared about the most only ever told him how bad he was. Michael felt hopeless. He could not see a time in his life when he would ever reach perfection. His solution to the problem was to end the pain. Michael ended the pain the only way he knew how. He killed himself.

Suicide is an issue of growing concern in the United States today. An attempt has been made in this paper to describe the different aspects of suicide and types of prevention used. The author also looks at where suicide prevention may be headed. Before examining these aspects of suicide, it might be helpful to define what suicide is. In the following section, suicide is defined, and the incidence and growth rates of suicide are discussed.

Definition and Incidence Rate

Suicide is the eighth leading cause of death in the United States today (Moscicki, 1995). It is an issue that has been widely discussed and studied at great length. Often, however, people can neither give it a clear definition or give answers for how it can be solved. It is a confusing subject, and for it to be discussed in any type of scientific manner, it needs to be defined. Suicide is, by definition, not a disease, but a death that is caused by a self inflicted, intentional action or behavior (Silverman & Maris, 1995).

Giving a definition to suicide helps paint a picture of what it is, but not how to help stop those people who are thinking about it. This is an issue that is pushing its way to the forefront of society by its increase in occurrence over the last 30 years. Since 1965, suicide rates among adolescents under 20 has increased from 6 out of every 100,000 people to almost 18 out of every 100,000 people (Shaffer et al., 1996). Other research indicates that suicide rates in males alone has sharply risen about 300 percent during the last three decades (Shaffer et al., 1996). It is an epidemic that is on the rise, and it

will be important for all people to know more about it. Because suicide is growing at such a steady pace, it will affect everyone in some fashion.

Suicide Causes

Even after defining suicide, it is difficult to understand the complexities involved with it. As mentioned earlier, suicide is not a disease. If it were a disease, the causes could be pinpointed and treated in some standard fashion. Suicide, however, is caused by a number of things. To make suicide even more complex, the very things that may lead one person to suicide may not even bother the next person. Because there is not one simple solution for how to stop suicide, it is important to look at the wide variety of causes for suicide.

Emotional Causes

One often-asked question about suicide is, "Why?" Why would a person commit or even think of committing suicide? Many studies have been done to try and answer this question (Linn & Lester, 1996). Research has indicated that some common reasons people commit suicide are for things such as low self-esteem, hopelessness, and feelings of failure (Linn & Lester, 1996). Additional research has suggested several other reasons such as unworthiness, grief strickeness, relationship problems, illness, family problems, substance abuse, and loss (Peach & Reddick, 1991). Each of these causes involves some type of emotional hardship. Knowing that emotional hardships are involved in suicidal thoughts, it would be beneficial to look at ways to help the suicidal person with his or her emotions before he or she achieves a distraught state.

Joiner and Rudd (1996) stated that two of the most widely known myths about why people might contemplate suicide are depression and loneliness. Depression is a state of being completely distraught. The truth, though, is that depression is not a cause for suicide (Joiner & Rudd, 1996). Depression itself is universally experienced

(Ramsey, 1994). It is the hopelessness that depressed individuals feel that causes the development of suicidality (Joiner & Rudd, 1996).

Many people also look at loneliness as a reason for suicidal thoughts. Joiner and Rudd (1996) found that loneliness does not create hopelessness, but that hopelessness creates the feeling of loneliness. Loneliness and depression alone are not causes of suicide, but can contribute to feelings of hopelessness and suicidal ideation (Joiner & Rudd, 1996).

Psychological Causes

Shneidman (1985) discussed the topic of commonalities or common characteristics in suicides. He stated that suicide commonalities can be applied to just about any suicide. Shneidman (1985) believed that people feeling suicidal are trying to escape pain, or as he puts it “escape the pain of feeling pain” (p. 124). He stated that such people are not getting their psychological needs met. Suicidal people see suicide as a solution to that problem. They feel helpless and/or hopeless and believe that no one can help, so they see suicide as that help (Shneidman, 1985).

Biological Causes

Researchers have also studied the biological aspects of suicide. Their focus has been on serotonin level in the brain. Mann, McBride, and Brown (1992) stated that serotonin levels in the brain are known to be remarkably stable over long periods of time. They also noted that this is helpful when researching the chemical levels in a suicide victim’s brain. Their research has indicated that over 95 percent of suicide victims in one study had a serotonin deficiency in the brain (Mann et al. 1995). They stated, however, that serotonin levels can not predict suicidal behavior. But it may help indicate who is at risk for suicidal ideation and behavior. Once at-risk people are targeted, suicide interventions may be used to help them.

Gender Factors

Gender factors are yet another area often studied when trying to understand suicidal behavior more clearly. Statistics have indicated that one man tries suicide in contrast to every six women (Piacentini & Rotheram-Borus, 1995). However, men succeed at killing themselves four times more than women do (Moschicki, 1995). Moschicki (1995) stated that men succeed at killing themselves more often than women do because men often use more destructive means to kill themselves. One such example of a destructive means of suicide for men would be the use of a gun.

Socioeconomic Status

Socioeconomic status is another factor related to suicidal behavior. The white male is known to be on top of the socioeconomic ladder in America. Many Americans also believe that happiness and contentment comes with being on top of the socioeconomic ladder. Research has indicated that about 73 percent of suicides committed in the United States are by white men (Moschicki, 1995). Ferrada-Noli (1997) was hoping to find that a poor socioeconomic groups had a higher suicide rate than those in a higher socioeconomic group. His research in the area of socioeconomic status and suicide rates were found to be inconclusive (Ferrada-Noli, 1997). This contradiction between societal beliefs and statistical findings shows how important research is for treating and reducing suicide.

Substance Abuse

Hepworth, Farley, and Griffiths (1989) brought up another major issue in society today: substance abuse. Research has indicated that the rapid increase in substance abuse over the last thirty years has a correlation with the increase of suicides (Hepworth et al., 1989). Several findings have indicated that between half and two-thirds of adolescents who committed suicide were involved in some form of drinking or

drug abuse (Hepworth et al., 1989). This supports the idea of Brent and Perter (1995) who advocated dual diagnosis and dual treatment. If a person is treated for one problem, the other does not magically go away.

Firearm Use

Yet another controversial issue in society is that of gun ownership in the United States. Brent and Perter (1995) suggested that much of the increase in suicide rates today is due to firearms. It is rare that a suicide occurs with a gun stored outside of the home. It is also rare that a suicide victim purchases a gun for the purpose of suicide (Brent & Perter, 1995). Stricter hand gun laws in certain states have shown a decrease in suicides (Brent & Perter, 1995).

Obstacles

Causes of suicide are usually intermingled with suicidal warning signals. People often see suicidal warning signals, but may never act upon them to intervene with the suicidal person. The following section contains a discussion of the common knowledge of warning signals that suicidal people give and the reluctance of other people to act upon those signals. This section also covers what it is that stops other people from reaching out for help after they know a person needs it.

Suicide Signs

Countless studies have listed suicidal warning signals to alert people of potential problems. Hepworth et al. (1989), Hendin (1991), and Silverman and Maris (1995) are some of the people who have studied these warning signs. They list some of the warning signs as: drug use, loss of appetite, sudden withdrawal from friends, talk of death, and deterioration of personal hygiene.

Suicidal warning signs are so commonly known that many laypeople could probably recount at least three suicidal warnings if asked. The difficulty, though, is that

the laypeople are not seeking help after the warning signs are observed. For example, a friend notices that Billy has been acting strangely ever since his girlfriend broke up with him. Billy buys a gun and also displays irrational and unusual behavior. The friend is concerned about Billy and takes the gun from him. The friend later returns the gun when Billy is acting normal. Two days later Billy, kills himself. The friend was concerned that Billy might do something harmful with the gun. Yet, the friend never asked anyone else for help. The question that therapists might need to ask themselves is: Why did the friend not call someone for help with Billy?

Suicide Stigma

Brent and Perter (1995) openly discussed the stigma associated with seeking therapy. Ramsey (1994) discussed denial of problems and lack of referrals in the effort to help people in need. These statements are a sharp contrast to the most effective therapy available today. Hendin (1991) stated that the best form of therapy for suicidal people today is the combination of diagnosis, medication, and therapy. Yet, the biggest hurdle for therapists is the diagnosis. This is not because of any lack in training or effort, but because they are not getting to the people who are suicidal. When therapists want to study suicide and suicidal behavior they seek information from such people as parents, friends, teachers, co-workers, and the attempters themselves (Hepworth, Farley, & Griffiths, 1989). Future researchers might want to look at reaching out to the suicidal person's support network for help. They may also want to look at how to build or create a support network for suicidal people who do not have one.

Interventions

Knowing what might cause suicide can help in trying to stop individuals who want to kill themselves. Once a person reports suicidal ideation, some type of intervention

needs to be implemented. The following section covers interventions that are currently used in the United States and information on how current interventions can be useful in creating more effective interventions for the future.

The understanding of how suicide manifests itself and the reasons why people are doing it is very important in assessing which people are at risk of suicide. It is also important information that can be useful in creating future interventions for people at risk of suicide. But before future interventions are developed, it is important to know what is being done currently in suicide prevention. It will be helpful to study current suicide intervention programs so the interventions that work can be kept and those that do not work can be discarded or improved. Combining what is learned through research with current successful interventions will only improve the existing intervention systems and pave the way to even better treatments for suicide.

School Interventions

It has been reported that suicide is the second leading cause of death for school-age youth (Peach & Reddick, 1991). This type of report shows how important a counselor's role is in helping suicidal teens. In a study by Peach and Reddick (1991), 63% of counselors thought suicide was a matter of serious concern. Yet, only 20% of those counselors stated that their schools had a suicide prevention or intervention program. Too often counselors are trained only to listen actively, assess for resources, and appraise for lethality (Lester, 1994). These strategies are aimed at targeting suicidal students, but do not suggest what to do after a student has been targeted as suicidal. Much of current school counselor training lacks an emphasis on a complete suicide intervention program.

Such a program would not only assess for suicidality, but also take action when a student is thought to be suicidal. That action might include a referral to an outside

agency for counseling or medication, connecting the student to a support system, or some form of hospitalization. This comprehensive program would include follow-up services as well.

Interventions for Recurring Suicide Attempters

For people who have actually attempted suicide, more serious action is needed. Generally, a person who has attempted or reattempted suicide will have a short hospital stay (Cotgrove, Zirinsky, Black, & Weston, 1995). Follow-up care after the hospital stay is recommended wherever possible (Cotgrove et al., 1995). This follow-up care is recommended because up to 50 percent of people who attempt suicide will try again, so it is important to stress continued or additional counseling (Piacentini & Rotheram-Borus, 1995). This push for continued care is especially important because studies on adults who have attempted suicide indicate that it is very difficult to keep them in follow-up counseling (Kerfoot, Harrington, & Dyer, 1995). It is not clear what needs to be done in the future to keep suicide victims in counseling, but some researchers like Piacentini and Rotheram-Borus (1995) are trying to find solutions to the problem.

A study done by Piacentini and Rotheram-Borus (1995) attempted tracking therapy attendance among adolescent and adult clients after a suicide attempt. They found that adult clients kept fewer appointments than did adolescent clients. Piacentini and Rotheram-Borus (1995) also found that vigorous case tracking had a significant impact on treatment attendance. If therapists contacted clients shortly after each treatment, the duration of treatment was longer than clients who were not pursued as aggressively (Piacentini & Rotheram-Borus, 1995). This type of research finding offers hope that trying new interventions may be more effective for suicidal clients.

Researchers are continuing to search for new suicide interventions because currently used interventions and types of preventions are not working effectively. This is evident because suicide completion has increased 300 percent in the last thirty years (Shaffer et al., 1996). The problem of suicide is no longer creeping its way into the forefront of society, it is here in full force. Because of the increase of suicide and because current steps to prevent suicide are not working, it is time to take progressive action to lessen this problem.

Innovative Prevention and Intervention Programs

Based on previous research, it is apparent that current prevention interventions are not working well enough. Researchers such as Silverman and Felner (1995) and Brent and Perter (1995) are looking at ways to improve the current intervention system. The following section covers innovative ways to improve the current suicide preventions and interventions.

Public Health Model

Many researchers such as Silverman and Felner (1995) discussed a progressive public health model. They looked at the idea of suicide prevention and broke it down into three different levels. These levels are described as tertiary, secondary, and primary intervention levels. Each of these three intervention levels also include medical, mental health, and human service interventions. Silverman and Felner (1995) said that a tertiary prevention focuses on people who have major disorders. They described a secondary prevention as one that targets people who display the early signs of a disorder. They also offered a primary prevention intervention that tries to prevent new disorders (Silverman & Felner, 1995). This three level model allows people to break the suicide problem into categories that may be more manageable. These categories would be more manageable because a therapist could target the

stage of the suicidal client and use interventions that apply specifically to that level of suicidal ideation.

Silverman and Felner (1995) also looked at the idea of reaching more people by having prevention be mass or population-focused. They recognized that a population-focused prevention plan is only one aspect of an action plan. Because of this realization, they did not propose to just speak to the masses. They also realized that not all persons in a population needed to be targeted for interventions so they developed a three tier intervention system. In Silverman and Felner's (1995) three tiered system, they wanted their interventions to be adjustable to the masses, subgroups, and individuals as well. They have set up a mass system that allows for attention to the individual. The biggest problem for Silverman and Felner (1995) is that the plan was written in theoretical terms. Their idea to inform a massive number of people was solid, but they did not give any concrete thoughts as to how this could be literally implemented into society.

Public Facility Programs

Brent and Perter (1995) had a partial answer to this problem. They suggested that mental health services should be set up inside of primary physicians' offices. This would stress the importance of mental health and reduce the stigma that goes with seeking out mental health services. They went on to say that because there is such a stigma about seeking mental health treatment, that universal screening for mental health problems may be a solution. They proposed that a school setting would be an optimal place for this to be done.

Brent and Perter (1995) discussed another major issue about the multifaceted suicide problem. They are proponents of dual diagnosis facilities. Individuals who have drug dependency and thoughts of depression need treatment for both. Brent and

Perter (1995) suggested that getting treatment for the substance abuse and ignoring the psychiatric problem will not make it go away. They noted that not offering a dual treatment could be fatal to the patient. Changing society's view of mental health treatment is vital to moving forward in the fight against suicide.

Home-Based Intervention

Brent and Perter (1995) also looked at what was happening following the release of suicidal people from treatment. Patients who have attempted suicide are often being released to poorly trained family members (Brent & Perter, 1995). Usually these families are coping with a large amount of stress and have poor communication as well (Kerfoot, Harrington, & Dyer, 1995). Psychopathology or substance abuse in a parent can also mean a greater risk in a child for suicidal tendencies (Brent & Perter, 1995). This offers a compelling argument for working with the entire family, not just the client. Having a mass system of education would help teach more people the skills they need to communicate about suicide and recognize warning signs (Silverman & Felner, 1995). However effective education may be, educating a mass number of people will not be enough to solve the problems in the homes of suicidal clients.

Home based interventions may be the answer to meeting the needs of the client, the family, and the income level at hand (Kerfoot et al., 1995). They suggested that therapists do home-based therapy. It would be less expensive because it would be shorter term than regular therapy. Kerfoot et al. (1995) saw the in-home therapy as being more accepted and easily understood by the family members. This therapy is meant to be intensive so that the family members have a goal and can see an end to the therapy. Kerfoot et al. (1995) saw the home-based therapy as a way to reduce noncompliance. By implementing the home-based therapy, their goal is to reduce

further episodes of suicidal behavior, help families improve communication, and to help families learn and develop better problem solving skills.

Hepworth, Farley, and Griffiths (1989) promoted family therapy for families of individuals who are suicidal as well. This is a way to change dysfunctional interactions between family members. It is a time for everyone to learn to respond in a more positive, supportive way. Hepworth et al. (1989) also noted that some parents are too supportive. These authors say some teens feel intense parental pressure to excel. This pressure to succeed can also cause suicidal behavior (Wetzler, Asnis, Bernstein-Hyman, & Zimmerman, 1996). It is important for family members to learn how to be supportive in ways that are helpful for each family member, especially the one with suicidal behavior.

Brent and Perter (1995) studied factors that were involved in reoccurrence of suicidal behavior and found the lack of family therapy to be one of the main factors involved. They found that the data suggested treatments that were family-based were more effective than individual therapy (Brent & Perter, 1995). They felt that one of the main parts of patient care should be the instruction on how to care for their child. Brent and Perter (1995), as well as Hepworth et al. (1989), believed that the family plays an important part in healing from suicidal ideation.

Along with family members, people involved in the at-risk person's life can help with suicide prevention (Hepworth et al., 1989). Suicide prevention therapy could benefit if people who were socially involved were aware of the power a social support system can give to a suicidal person. Hepworth et al. (1989) also stated that suicide is not the result of pressure, but the result of pressure without social support. The challenge for the future is to define the social support system. A person's support

system may appear to be in place to others, but if the client is looking for support from some other source, the issue becomes even more complex.

One example of a weak support system might be as follows. Jill has a great family that is very loving and involved. It would appear that she has a strong support system. Jill, however, is in love with Brian and wants to make him happy. Brian never acknowledges Jill. Jill, then, does not have a good support system because she considers Brian her support. A question to answer is: if a person has complete support in every aspect of his or her life, but has none from one desired source, does he or she really have the support needed? Researchers such as Leduc and Labreche-Gauthier (1992) do not think so.

Back to the Future

Even with all the innovative prevention ideas offered, there is no solution given. Because there is no answer to the suicide problem, researchers will have to continue to do their work. Even so, information from past research can be pieced together with information from future research. For this to happen, the realistic information from research must be separated from the unrealistic.

For example, Silverman and Felner's (1995) idea of a mass population approach to treatment is probably not realistic because of funding and communication barriers. But Brent and Perter's (1995) idea of reaching a mass number of people by screening children in a school setting is more realistic because it would not be very costly or time consuming. These ideas are helpful, but they are not a complete suicide prevention system. One such realistic and manageable prevention program is offered below.

Cotgrove et al. (1995) did a study of secondary prevention on attempted suicide and generated some suggestions for help in the future. Their study might not work as well for people who have never sought help, but it could help those who have had a

previous primary suicide attempt. Their study focused on giving green cards to the clients who had previously attempted suicide (Cotgrove et al., 1995). The green card was explained to the clients as a sort of pass for them to receive immediate help at a hospital. This was thought to be a way for them to feel empowered and not hopeless.

Cotgrove et al. (1995) set up the green card system to allow clients to use the green card for services at a hospital when they needed them. The clients would be in control of saying when and if they needed help. They did not have to rely on a therapist or anyone else to admit them. They thought this would help take away some of the stigma of seeking therapy. Cotgrove et al. (1995) also wanted to provide the clients with a means of escape from distressing situations. They wanted clients to have a way to be taken seriously when help is needed. They also wanted clients to have a way to make a statement to others that they are in distress without using self-harm. Lastly, they wanted to give the clients solid proof that therapists have a true interest in their well-being. This type of system would be time and cost efficient, and it would also be able to take place right along side regular therapy sessions too.

Critics were afraid that these green cards would be abused and that hospitals would be flooded with these patients, but Cotgrove et al. (1995) found the opposite to be true. Clients did not abuse the cards; in fact they rarely used them. It appears that the mere presence of such an option allowed them to use different solutions to their problems (Cotgrove et al., 1995). This could be one step in the right direction.

As stated earlier, it is not likely that mass education on suicide will sweep the nation. Funding and time efficiency are the downfall of such an idea (Silverman & Maris, 1995). Suicide is not seen as a large enough issue to warrant such attention. Silverman and Maris (1995) suggested that suicide education be implemented into programs that are already in existence, like wearing seat belts, school programs, or

carbon monoxide testing. Schools are the easiest place to reach many people where mass education is concerned (Silverman & Felner, 1995). If everyone is being tested, there is no stigma. People would become familiar with the testing procedure, and it would be normalized. Hopefully, current research, combined with future findings, may help to reduce or even prevent suicide in society. No matter at what stage suicide research is, whenever suicide prevention can be communicated, it will benefit someone.

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